STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	010235	A. BUILDING: _____ B. WING _____	C 10/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOUR ASSISTED LIVING OF FORT WAYNE	3110 E COLISEUM BLVD FORT WAYNE, IN 46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for the Investigation of Complaint. IN00137219. Complaint IN00137219 - Unsubstantiated due to lack of evidence. Survey dates: October 2, 3 & 4, 2013 Facility number: 010235 Provider number: 010235 AIM number: N/A Survey team: Virginia Terveer, RN, TC Julie Call, RN Census bed type: Residential: 63 Total: 63 Census payor type: Other: 63 Total: 63 Sample: 4 Harbour Assisted Living was found to be in compliance with 410 IAC 16.2 in regard to the Investigation of Complaint IN00137219.	R 000		